Tourism and HIV
Involving Women in the Design of Educational Materials in Rural Costa Rica

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ABSTRACT: This article describes the involvement of women from rural Costa Rica, where tourism is predominant, in the creation of HIV/AIDS awareness materials that are appropriate for families and peers. The project was conducted in four towns in the Monteverde Zone, a region that has experienced a transition from an economy based on agriculture and dairy farming, to one dependent on tourism. Informed by previous research that shows the significant impact of tourism on the economic and social landscape of the zone, this project responded to local residents’ desire for participatory approaches to raise awareness about the potential spread of HIV/AIDS in their communities.

KEYWORDS: applied anthropology, Costa Rica, HIV awareness, tourism, HIV

Introduction

Worldwide, the number of people living with HIV infection has been estimated at 33 million (Kilmarx 2009; UNAIDS 2010). About two thirds of these cases (22.5 million) are found in sub-Saharan Africa (UNAIDS 2010), followed by South/Southeast Asia (3.8 million), Latin America (2 million) and North America (1.4 million) (UNAIDS 2009). Heterosexual sex remains the most common mode of HIV transmission worldwide (Higgins et al. 2009; Kilmarx 2009; UNAIDS 2010), with localized pockets where other modes are more prevalent (e.g., male-to-male contact in Latin America and injection drug use in Asia) (Kilmarx 2009; UNAIDS 2009).

Although epidemiological data allow for prevention efforts targeted at people who engage in particular behaviours, the placement of people into ‘risk groups’ is ‘falsely reassuring’ and ‘inappropriately stigmatizing’ (Farmer [1997] 2010: 121). Instead, patterns of infection should be mapped according to social, economic and historically created realities which consider the influence of gender, power differentials, poverty and inequality (Farmer [1997] 2010). Those labelled ‘high risk’ often face additional stigma and victim-blaming (Schiller et al. 1994; Parker 2001; Madru 2003; Guttman and Salmon 2004). The focus on individual behaviour and the ‘high risk’ groups created from them, has led to the design of public health interventions that attempt to change behaviours without consideration for the ‘social, structural, and cultural factors’ which often limit personal agency (Parker 2001:165).
Additionally, the epidemiological and public health emphasis of risk groups may allow some susceptible to the disease to slip under the radar, especially married women, who according to a United Nations report, are at increased risk due to their marital status alone (Farmer [1997] 2010). With just over half of worldwide HIV infections occurring in women (Kilmarx 2009; UNAIDS 2010), researchers refer to the ‘Feminization of HIV’, and call for the consideration of biological susceptibility, gender roles and gender inequities in terms of economics and household decision-making in the creation of HIV-prevention programmes (DeLay 2004; Higgins et al. 2009).

Equally important is the consideration of the impact that overarching forces such as globalization and its associated population movement have on the spread of sexually transmitted infections (STIs) (Lurie et al. 1997; Singhanetra-Renard 1997; Romero-Daza and Himmelgreen 1998; Upton 2003) – in particular, the role of tourism in the spread of HIV and other STIs (Forsythe et al. 1998; Skoczen 2001; Wonders and Michalowski 2001; Agrusa 2003; Flucker and Deery 2003; McKercher and Bauer 2003; Kempadoo 2004; Romero-Daza and Freidus 2008). While research has emphasized the role of sex tourism (i.e. travel to specific sites with the intent to engage in sexual relations with local residents) in HIV transmission between tourists and commercial sex workers (Forsythe et al. 1998; Kerrigan et al. 2001; Skoczen 2001; Agrusa 2003; Kempadoo 2004), less is known about the impact that other types of tourism (that is, not specifically motivated by sexual pursuits) may have on local residents. In addition to sexually transmitted disease transmission, Honey (2010: 442) suggests the downside of tourism can result in ‘prostitution, crime, black marketeering, gambling, [and] drugs’.

The impact of tourism is also felt in other areas of life. For example, although the financial benefits derived from the tourism industry are numerous, local residents also experience some ill-effects in terms of food access and availability. Specifically, local grocery stores elevate prices to capitalize on tourist business, and costs remain exorbitant for less affluent locals, effectively limiting access to fresh foods (Stem et al. 2003; Himmelgreen et al. 2006). Further, small-scale food production becomes less feasible when the tourist industry is a primary source of employment, leading residents to rely upon purchased, less nutritious staple foods (Stem et al. 2003; Himmelgreen et al. 2006). Additionally, tourism creates a type of cultural erosion, created by a ‘commodification’ of local people and their culture (Mowforth and Munt 1998; Stem et al. 2003: 325).

Following up on previous research on the impact of tourism on the potential spread of HIV/AIDS in rural Costa Rica (Romero-Daza and Freidus 2008; Freidus and Romero-Daza, 2009), this article reports on an applied project designed to involve local women in the creation of HIV/AIDS awareness materials for their peers and their families. The project was conducted in four towns in the Monteverde zone of Central Costa Rica, an area that is experiencing rapid economic and social changes associated with globalization in general, and with a growing tourism industry in particular (Himmelgreen et al. 2006). Given the low rates of HIV infection in the area, the Monteverde zone offers an ideal setting for HIV/AIDS prevention efforts. We argue for the adoption of a bottom-up approach to HIV/AIDS prevention that actively engages the intended ‘consumers’, and that directly responds to the realities brought about by the influx of tourists to this area.

The Setting

The project was conducted in the Monteverde zone, in Costa Rica, a rural area in the Tilaran mountain range in the Puntarenas Province. The region includes over 20 towns of varying sizes and is home to approximately 6,000
residents, including the predominantly North American Quaker community, nestled in the upper-region of the zone near the Monteverde Cloud Forest Preserve (Honey 1999; Vivanco 2006). Before the arrival of the Quakers, the zone had been inhabited by native Costa Ricans ('Ticos') since the 1920s (Vivanco 2006). Although not fully documented or archived, there is artefactual evidence (e.g., pottery and tools) of an earlier indigenous culture that has been found by local farmers (Personal Communication, Noe Vargas, 2011). Ticos and Quakers live there year round, while increasing numbers of tourists, students and researchers visit seasonally to vacation, study and conduct research (Himmelgreen et al. 2006).

After the Quakers arrived in 1949, they, along with local Ticos, worked together to develop an economy primarily based on dairy farming, mostly milk and cheese, coffee production, and, more recently, the sale of fruits and vegetables to local restaurants and hotels, and to tourists and locals. While historically, small family farms have been an important feature in the economy, during the last three decades the tourism industry has flourished and the area has experienced a considerable influx of tourists. For example, in 2008 alone, over two million tourists from North America, Europe and Central and South America visited Costa Rica (Instituto Costarricense de Turismo 2009). Today, the Monteverde zone is considered the second most popular tourist destination in the country. The 40-km still largely dirt-covered road that goes from the Pan American Highway to the uppermost Monteverde Cloud Forest Preserve, passing through towns such as Santa Elena (a tourist hub) and Monteverde along the way, brings 250,000 tourists annually to the zone. The number of tourists visiting this area is likely to increase substantially once the road is completely paved (Monahan 2004).

The influx of tourists into the zone and associated economic and lifestyle changes are having a significant impact on its residents’ overall well-being. An area of increasing concern is the rapidly changing diet and physical activity patterns, which have resulted in obesity among local residents, and them becoming overweight (Himmelgreen et al. 2006, Himmelgreen et al. in press). Such increases are of importance due to their association with chronic diseases such as hypertension, diabetes and cardiovascular disease (Dinour et al. 2007; Hanson et al. 2007; Martin and Ferris 2007). Equally alarming, but not widely documented, is the potential spread of STIs, including HIV/AIDS associated with population movement in general, and with tourism specifically. Compared to other Latin American countries, Costa Rica seems to fare well in relation to HIV/AIDS, with rates of infection estimated at 0.6 per cent in 2003 (UNAIDS 2009, 2010). However, this apparent trend may not be accurate as reporting and testing are limited within the country in general and very low in the study area in particular. Multiple factors such as early onset of sexual activity, limited HIV education, lack of awareness about the importance of testing, and limited access to resources, including condoms, create a volatile situation that could lead to considerable increases in rates of infection, as has been seen for example in Jamaica.

In 1999, much like in Costa Rica, Jamaica maintained a low prevalence of HIV/AIDS, with around 0.7 per cent of the adult population infected (Olukoga 2004). However, this situation changed rapidly, spiking to 1.5 to 2.0 per cent only three years later in 2002 (Olukoga 2004). Determinants are said to mirror those previously mentioned in Costa Rica, including early sexual debut, poverty, infection with STIs and, notably, tourism (Olukoga 2004). Similarly, other Caribbean countries, particularly the Dominican Republic, are said to have rising HIV/AIDS rates due to increases in tourism; men working in tourism industries may not identify as ‘sex workers’ but engage in sexual activities with travellers, who are perceived as a lucrative source of income (Padilla...
et al. 2010: 71). U.S. visitors account for nearly half of Costa Rican tourism (U.S. Department of State 2012), which is particularly worrisome for international transmission considering that the United States has ‘one of the highest adult rates of HIV in the Western Hemisphere’ (Padilla et al. 2010: 71). Padilla and colleagues (2010) also cite the recreational use of drugs and alcohol among tourists, which may lower inhibitions and encourage sexual encounters with locals, a phenomenon also observed in Costa Rica as discussed below.

Our previous research in the Monteverde zone provides evidence for the impact of tourism on practices that increase the risk for STIs in general, and HIV/AIDS specifically (Romero-Daza and Freidus 2008; Freidus and Romero-Daza 2009). The research team involved in the project reported here conducted 57 in-depth interviews with individuals directly involved in the tourism industry (e.g., hotel owners and operations, bar tenders, tourist guides), healthcare practitioners, teachers and school administrators, religious leaders, local government officials, parents of teenagers, and community leaders. In addition, we facilitated 10 focus groups with over 60 young adults, including many foreign females who were long-term visitors to the area and who were engaged in relations with local men. We collected survey data from 160 short-term visitors (i.e. tourists who remain in the area for less than two weeks). Finally, we conducted participant observation in many of the settings where tourists and locals congregate. Data collected from bars, discos, restaurants and Internet cafes were useful for the assessment of behaviours (e.g., drinking, use of other drugs, and ‘hooking-up’ with potential sex partners) that may contribute to the spread of STIs including HIV/AIDS.

One of the main findings of the study was the overall concern about the impact that tourism is having on sexual and drug-using behaviours among residents of the Monteverde zone, both youth and adults. According to the participants, these changes include increased use of alcohol and marijuana and involvement in sex with casual partners, group sex and same-sex relations. As reported, many of these sexual relations may be unprotected, given the limited availability of condoms.

Of special importance is the involvement of young foreign women (especially American and European), with local men of all ages. The men, who self-identify as gringueros (i.e. local men who actively seek relationships with foreign women), consider tourist women to be more sexually liberated and less controlling than local Costa Rican women. On the other hand, the foreign women, who often hold stereotypes of the suave ‘Latin lover’, quickly fall into what they consider to be serious romantic liaisons. While condoms may be used early in such relationships, they are quickly abandoned, either because of lack of access or, more commonly, because of men’s preference. To complicate matters, it is not uncommon to find that in addition to engaging in relations with foreign women, many of the gringueros are also involved in more permanent relations with Costa Rican girlfriends and wives. This latter point is of great relevance, since it underscores the fact that local women who may be monogamous and do not engage in behaviours such as drug use, may still be a high risk for HIV/AIDS through their male sexual partners. This heightened risk faced by local women and, through them, by their children, was a constant focus of concern expressed by our research participants.

Not surprisingly, when asked to identify areas of action for preventing HIV/AIDS, stakeholders from many different segments of the community pointed to the urgent need for the development of HIV/AIDS awareness and prevention materials that are targeted not only to specific groups such as gringueros or female tourists, but also to local women and their families. Participants reasoned that a family-targeted approach would be much more effective in raising awareness about HIV/AIDS
among people of both sexes and of many different age groups (including young and old gringueros). Moreover, they argued that local women who have children would be the most appropriate conduit for such initiatives, since they play a central role in family life. Finally, respondents stressed the fact that, while some prevention materials (e.g., educational pamphlets) are available through the local clinic and doctor offices, they are usually abstract and full of medical terminology which makes it difficult for the average person to understand. In their view, this underscores the need for educational materials that are culturally appropriate and that respond to the day-to-day reality of rural Costa Ricans whose daily lives are directly impacted by their involvement in the tourism economy.

**Traditional Approaches to HIV/AIDS Education**

HIV/AIDS prevention and education materials are often guided by a top-down, ‘one-way’ mode of communication which fails to consider the complexity of social, economic and political factors, as well as the communication needs and styles of the communities at which they are directed (Asthana and Oostvogels 1996; Eggins et al. 2011: 3). Additionally, following common public health models that place the onus of responsibility for health on the individual, HIV/AIDS education efforts continue to be focused on changing individual behaviours that increase HIV transmission risk (Aggleton 2004; Piot et al. 2008). Such emphasis on individual behaviour ignores the fact that such behaviours rarely occur in isolation, and that individuals are embedded within larger structures including family, social and religious groups, and institutions, all of which ‘structure the interactions that take place and the results that emerge’ (Cornish and Ghosh 2007: 497).

A considerable proportion of HIV/AIDS education materials use fear as an attempt to motivate people to adopt protective behaviours (e.g., condom use, avoidance of the sharing drug injection equipment) (Agurto et al. 2005). Often times, such approaches consider cultural differences as barriers to behavioural adoption or as the reason for disappointing programme results (Airhihenbuwa et al. 2000). Quite frequently, messages intended to reduce HIV/AIDS risk actually ignore discussions of sexuality because of its nebulous and stigmatized nature (Aggleton 2004; Piot et al. 2008). While well intentioned, many HIV/AIDS education campaigns that use this top-down, fear-fostering approach, fail to achieve their goals (Sormanti et al. 2001; Batrouney 2004). In addition to these factors, exclusion of community participation in the planning process has been named as a ‘major cause’ of ineffective or failing prevention programmes (Munodawafa et al. 1995). Thus, it is important to adopt participatory methods that involve the intended recipients of information in the actual development of health education and disease prevention materials. Participatory methods are particularly suited for HIV/AIDS prevention initiatives, given that the sensitive nature of topics such as sexual behaviour and drug use requires careful considerations of the perspectives and preferences of the ‘target population’.

Involving the local community in the research and planning process is not a new concept; the 1978 Alma Ata Declaration (Asthana and Oostvogels 1996) and more recent UNAID strategies (Airhihenbuwa et al. 2000) push for the inclusion of community participation to create more effective, locally grounded educational materials and programmes. The effectiveness of this approach, especially in developing countries, has been shown in projects dealing with a variety of health topics including cervical cancer in El Salvador (Agurto et al. 2005), and HIV prevention among youth in South Africa (Campbell and MacPhail 2002) and in Papua New Guinea (Eggins et al. 2011).

Bishop criticizes traditional Western researchers for conducting research according to
their own agenda, calling for greater flexibility on the part of the researcher who should challenge ‘the locus of power and control over the research’, thereby creating a more ‘collectivistic’ effort (1998: 201). The adoption of this ‘indigenous approach’ allows for local peoples to turn the focus of the research to include their own ‘aspirations, preferences and practices’ (Bishop 1998: 201). To be successful, it is necessary to reverse the participatory roles of researcher and participants where the individual goal of the ‘researcher is released in order to enter a consciousness larger than the self’ (Bishop 1998: 205). Further, establishing a relationship between local participants and researchers equalizes power dynamics, and creates a researcher who is one of many ‘stakeholders in the relationship’ (Eggins et al. 2011: 6).

Health promotion initiatives that involve local participants in the creation of educational materials and programmes which are rooted in community history, social relations and cultural understanding, maximize the effectiveness of interventions by responding to the needs, desires and preferences of those for whom they are intended (Campbell and MacPhail 2002; Eggins et al. 2011). Additionally, such participatory endeavours also increase the sustainability of the resulting programmes by increasing a sense of ownership among participants (Agurto et al. 2005). Encouraging participants to become agents of their own health changes is empowering, and provides them with an ‘authoritative voice’ of their own outside of researchers and local organizations (Bishop 1998: 200). Due to their intimate knowledge of local milieux, individuals from the target population who are engaged in the creation of health materials can offer valuable insight not only about what should be included in such materials, but also about what should not be included, in efforts to conform to context-specific mores and preferences. A principal theme that emerges from the literature on participatory research for health promotion is the need to create a meaningful dialogue with members of the group for which educational/preventive efforts are intended.

**Engaging Women as Agents of Change**

Based on research participants’ recommendations and the study findings, we sought to develop and implement a pilot intervention project that actively involved members of the local community in the creation of HIV-prevention materials. The project was conducted in early 2005 and was based on a community participatory framework, which considers members of the ‘target population’ as equal partners in any and all endeavours, and as experts whose input contributes greatly to the formulation of culturally appropriate interventions. We decided to follow the advice of local participants and work exclusively with adult women, one of the groups identified as being in great need of education and prevention, but which, at the same time, is one of the most influential in the domestic and public arena, and one that is indirectly but potentially very drastically affected by the tourism-driven risk in which their partners are involved. We used a comprehensive model that combines research, education, and development and small-scale production of education materials and that stresses the importance of adopting a bottom-up approach to the creation and delivery of health initiatives.

The original idea for this intervention and the specific details of the programme were generated by one of the co-authors (Ramirez-Rubio) and her colleagues (see the acknowledgments section below) when they participated in the Globalization and Community Health Field School, an intensive summer programme (a collaboration between the University of South Florida and the Monteverde Institute) that provides students with training in qualitative and quantitative methods used to conduct health-related research in communities undergoing rapid social and economic changes.
Following the recommendations of women who participated in Ramirez-Rubio and colleagues’ study, we decided to expand the project to four towns in the Monteverde zone. All the towns were within about eight kilometres of each other, had medium-size populations (about 300 to 500 individuals each), and were characterized by economies that combined both agriculture and tourism, although to different degrees. The project involved a total of 40 local women (10 in each town), recruited through door-to-door outreach and word of mouth. Participants ranged in age from 23 to 54 years, all were married or in permanent long-term relations with a live-in partner who was typically involved in tourism, and had between one and four children (ranging in age from four to 31). All participants had at least six years of formal education, with most having completed high school.

The overall goal of the project was to involve the women actively in the design and creation of HIV/AIDS awareness materials that could be distributed throughout local communities. In each of the towns, the project was structured as a series of four weekly workshop sessions, each of which built on the previous one. The workshops were led by female facilitators who were native speakers of Spanish and knowledgeable about the communities in which they were working. All the facilitators were also researchers and had completed the human subject certifications, had experience conducting group educational activities, and were well respected in the communities. The workshops were conducted in settings such as community centres, or in the local elementary school. The goal of the first session was two-fold: first to assess the level of HIV/AIDS knowledge among participants, and second, to provide the most up-to-date information on the topic to fill in any existing gaps in knowledge and to dissipate any misconceptions that might exist. During the second session, participants were involved in the evaluation of existing HIV/AIDS education materials used in Costa Rica. This was achieved through both individual and group-level activities that allowed the women to express their opinions in a collegial, non-threatening setting, and that emphasized the value of their opinion as consumers of health initiatives. The last two sessions were centred on hands-on activities that allowed the participants to conceptualize and design HIV/AIDS materials that they considered appropriate to disseminate information in their own communities. In each of the four towns, the women worked together to (a) identify the specific demographic group they would like to have as the main target audience for their educational materials, (b) create the actual content of the education/awareness messages, (c) determine the specific format for the delivery of such messages, and (d) produce a sample of the intended material.

Final Products

As mentioned above, in each town the women agreed on a specific target audience for their HIV/AIDS education and awareness efforts, and constructed their materials accordingly to fit the needs and preferences of such a group. In the first town the participating women collectively decided that their target audience should be the entire family. The women reasoned that, given all the changes that have been introduced to their rural areas through tourism, there is a need to increase awareness about HIV/AIDS among people of all ages. The women in this group specifically mentioned their concerns for their teenage children — especially their sons — who often abandon their education in order to participate in the tourism industry. As they stated, while contact with tourists has many benefits, it also introduces changes in attitudes and behaviours that may increase the risk young people face in relation to HIV and STIs (see also Romero-Daza and Freidus 2008 for a full discussion of these concerns). With the need to address families
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In mind, the women in this group created a 12-page wall calendar, with culturally appropriate images and messages related to HIV for each month of the year.

In the second town the women decided to convey their HIV/AIDS awareness messages through key chains. They reasoned that such utilitarian objects that can be used on a daily basis by men and women of different ages would be the perfect medium to educate not only the owners of the key chain — who would constantly be reminded of the messages — but also those with whom he/she interacts — including tourists — given that key chains are highly visible objects that are publicly displayed during many daily social interactions.

In the third town, the women chose as their target audience teenage girls and young adult women, whom they considered to be at special risk for STIs including HIV/AIDS given factors such as the limited sexual education imparted at schools, the difficulties parents have talking openly about sexual matters, and the fact that these young women may involve themselves with gringueros, who put them at risk for HIV and other STIs. In order to respond to the needs of this sub-group, the women created a combination of notebooks/address books that were highly utilitarian, but that conveyed a myriad of information regarding HIV/AIDS.

Finally, in the fourth town, one in which the economy is mostly dependent on tourism, the women engaged in a lengthy discussion about the impact that the influx of tourists has on the potential spread of HIV and other sexually transmitted infections in the Monteverde zone. Based on this, they chose foreign tourists, and specifically foreign women, as the main intended audience for their educational/awareness efforts. The rationale for this selection was the high frequency of relationships that are established between local men and these female visitors (as described above). In their discussions, the women talked about the factors that lead local men to involve themselves with foreign women, and recognized that local women were put at risk through the behaviour of their male sexual partners. While the women in the group believed men should be educated, they emphasized the fact that foreign women bore much responsibility for their actions, and should be the target of specific campaigns stressing the use of condoms. As a group, the women decided the most effective way to reach their intended audience was through the use of posters that could be easily displayed in places where tourists and locals congregate and where many relationships get started, namely bars, nightclubs and Internet cafes. The women also insisted that the mes-
sages should be delivered in English (or in a bilingual format) rather than in Spanish alone, to have a greater impact among tourists, many of whom may not be familiar with the local language.

Closing Activities

After the four sessions were completed and the final materials were produced, the women were involved in planning the closing activities for the project. Again, as throughout the entire project, the women had control over final decisions regarding the number, content and format of the activities, as well as over which groups of stakeholders would be invited to the event. The facilitators simply assisted with the logistics, without interfering with the decisions made by the women. The result was a day-long celebration in which all the women who participated in the project got together in one of the community centres. Other attendants included the local artists who assisted with the production of the educational materials, friends and families of the participating women, and special guests from the local government and the health sectors, among others. Informal conversations with the women during the closing event and in subsequent interactions with the facilitators indicated that they saw their participation in the project as a very positive experience. In addition to feeling pride and self-satisfaction when seeing the materials they created reproduced and distributed in their communities, the women valued the opportunity to work together with their peers in a context that fostered appreciation and respect for the views of others while dealing with a topic that is still shrouded with secrecy and fear. More importantly, they saw this experience as an opportunity to discuss openly the ways in which tourism affects the daily lives of individuals in the context of romantic relations, sexual encounters and potential spread of diseases.

Conclusion

The above description exemplifies the design and implementation of a project that actively involves members of local communities in the creation of materials to raise HIV/AIDS knowledge and awareness. Such a bottom-up approach has several advantages. First, by emphasizing the value of the opinions, perspectives and input of local participants, this approach acknowledges the important role ‘consumers’ can play in the creation of effective educational materials (Agurto et al. 2005; Butterfoss 2006). This increases a sense of validation, pride and ownership among those who take part in the process. Anecdotal evidence for this includes an interaction one of the authors (Romero-Daza) had a few years after the project had been completed. While taking part in a community activity, the author was approached by two women who identified themselves as having participated in the creation of the 12-page wall calendar. The women explained that even though the calendar itself was now useless (it was out of date given the time that had elapsed) they still had it prominently displayed on the wall of their kitchens. The women further explained that they felt empowered by the project and that, since then, they had taken it upon themselves to talk to others about HIV/AIDS, especially emphasizing the implications that involvement in the tourism industry has for men — both young and old — and for the local women with whom they have permanent relations.

Second, by giving participants the freedom to choose what to communicate and how to do so, this approach greatly contributes to increasing the cultural appropriateness of the resulting educational/awareness materials, a much sought-after goal in HIV/AIDS campaigns (Parker 2001; Wilson and Miller 2003; Halperin et al. 2004). In this project, this was exemplified by the participants’ incorporation of references to specific activities commonly practiced in the area (e.g., soccer, bull-fighting,
hiking), to the surrounding environment (e.g., common plant and animal species, cloud-forest imagery), to common social interactions (e.g., socializing between locals and tourists), and even to dates of historical significance (e.g., Costa Rica national independence day, annexation of a province to the country). This represents a valuable opportunity to expand HIV/AIDS education and awareness campaigns by moving away from a focus on exclusive depictions of ‘high risk’ sexual and drug use practices, and towards educational efforts that contextualize ‘risk’ in the overall frame of the day-to-day life of individuals and communities, as influenced by global forces.

Third, by allowing participants to choose the most appropriate format for the delivery of HIV/AIDS information, this bottom-up approach also expands our ideas about innovative ways to disseminate prevention and awareness information. In this project, this is evidenced by the decision of three of the groups to deliver their messages through the creation of highly utilitarian objects (e.g., wall calendars, key chains and notebooks) that are frequently and constantly used in normal day-to-day activities. The use of utilitarian objects as media for the dissemination of HIV/AIDS messages may contribute to making HIV/AIDS part of the day-to-day discourse of social interaction. As the women who participated in this project reasoned, this ‘normalization’ of HIV/AIDS may very well help in making it less of a taboo topic, and may facilitate the engagement of individuals and communities in a more open discussion about a health condition that is still very much shrouded in secrecy and stigma.

Finally, as discussed by the women, the process of active engagement and participation fostered a strong sense of group identity and provided a safe setting for the exchange of ideas in a non-threatening environment. They recommended that the project be expanded to other local groups including teenagers and young adults, men in general — and gringueros specifically. We do believe this is an appropriate route of action and hope to obtain funds to continue our work with these and other groups in the Monteverde area.

While the role of sex tourism on the spread of HIV and other STIs has been discussed in the literature (Forsythe et al. 1998; Kerrigan et al. 2001; Skoczen 2001; Agrusa 2003; Kempadoo 2004), less is known about the impact that other types of tourism (e.g., eco-tourism) may have on the health risk of local residents and their families. The Monteverde zone provides an ideal natural laboratory in which to study the latter. These concerns are reflected in the HIV and STI educational and awareness materials that the women developed. Two out of the four groups of women developed materials that specifically address tourism (or at least behaviours associated with tourism) as a risk factor for HIV and STIs. One group of women targeted young female tourists by promoting condom use, and distributed materials in venues (e.g., bars) where tourists are likely to meet local men and possibly become involved with them. The other group of women developed materials intended for their families, especially their sons, many of whom land up working in the tourism industry after finishing school. Because of limited employment opportunities in the zone, many young people are moving away or taking jobs in the local tourism industry. In this case, these women associate tourism with changing attitudes and behaviours that promote alcohol and drug use, sexual promiscuity and unprotected sex.

The results presented in this article demonstrate that the study participants are cognizant of the potential role of tourism on the spread of HIV and STIs as a result of changing attitudes and behaviours and increased interactions between locals and tourists. This is not to say that locals in the Monteverde zone wish that tourism would disappear. On the contrary, they recognize that tourism is an economic life-line and that there is also an upside to touristic activities including the opportunity for cultural exchange among other things. Finally,
the findings underscore the need to further develop culturally appropriate education and awareness materials that come from the community and are not imposed from the outside. In light of the low rates of HIV and other STIs in Costa Rica, a country characterized by tourism, it is an imperative that more resources be dedicated to this endeavour in order to stave off these diseases in the future.

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References


Instituto Costarricense de Turismo (2009), Anuario Estadistico de Turismo (San José, Costa Rica: Instituto Costarricense de Turismo).


